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Citation

Brigham, Lindsay L. and Smith, Ann G. (2008). 'Riding the waves' - an exploration of how students undertaking a pre-registration nursing programme develop emotional resilience. Open University, Milton Keynes.

URL

<https://oro.open.ac.uk/34472/>

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'Riding the waves' - an exploration of how students undertaking a pre- registration nursing programme develop emotional resilience.

1. Introduction

The study was prompted by recognition of the many emotional demands and challenges on mature students undertaking professional programmes, not only of acquiring and utilising new academic knowledge and practice skills but of adapting to different and increased responsibilities that require "thinking on your feet."

The broad aim of the study was to *gain more understanding of the ways mature students, undertaking the adult and mental health branches of a pre-registration nursing programme, use and develop emotional resilience in response to these challenges, during their transition from health care support workers to accountable professionals.* This greater understanding was then to be utilised to make recommended changes to the delivery of professional programmes, in relation to curriculum, pedagogy and student support systems, to promote the development of emotional resilience in individuals. The assumptions underpinning the study are that a) students bring to the learning process both experience and resilience b) that undergoing a professional programme has a profound impact on both epistemological and ontological processes that interact in the further development of resilience, bringing to the fore questions relating to both "what I know" and "who I am". These questions ultimately have an impact on practice so "knowing", "being" and "doing" are closely interrelated.

The study was organised in a number of stages (not necessarily chronological) that are reflected in the structure of this report.

- Undertaking a literature review to develop a working definition of emotional resilience based on current research. Emotional resilience is a term that is increasingly found in academic and popular literature but is used in rather different ways by authors and its meaning is often conflated with other concepts such as emotional intelligence, emotional capital and emotional labour.
- Using the working definition of emotional resilience to set the research questions and design the methodological framework
- Carrying out a focus group and series of in depth qualitative interviews
- Analysing the data around a) different challenges faced by the students and b) categories and dimensions of resilience and discussion of processes with reference to existing literature. Making recommendations for curriculum development, pedagogy and student support based on findings.

- Exploring broader theoretical frameworks to make sense of the data, primarily Wenger's notion of *communities of practice* with some reference to approaches that place greater emphasis on discourse, knowledge and power.
- Utilising these frameworks to further analyse the development of resilience in the situated context of nursing practice and foregrounding engagement and participation within relevant communities of practice
- Identifying areas for further investigation

2. Literature review – developing a working definition of resilience

Existing literature on emotional resilience approaches it from a variety of different perspectives but emphasis has shifted over time. Earlier theorists constructed resilience as a reasonably stable personality characteristic but more recently it has been viewed as a multidimensional concept, which also takes into account more structural characteristics such as age, social class, culture, history, gender and support networks in the immediate social environment.

Generally, resilience has been seen as an individual's ability to thrive and fulfil their potential despite, or perhaps as a response to, stressors. Resilience and coping are related concepts but coping refers to the cognitive and behavioural strategies used for managing the demands of stressful situations whereas resilience refers to the adaptive outcomes which occur (Campbell-Sills, Cohan and Stein 2006). Supporting a person's strengths and moving them towards functional coping is said to be a key contributor to the achievement of resilience (Edward and Hercelinskyj 2007). In terms of the individual, resilience can be seen as 'a combination of abilities and characteristics that interact dynamically and allow an individual to bounce back, cope successfully and function above the norm in spite of significant stress or adversity (Tusaie and Dyer 2004:3)'.

Many studies have been undertaken to identify the characteristics and determinants of resilience in children and adults (e.g. Wilkes 2002, Hammond 2004, Denny Clark, Fleming and Wall 2004, Campbell-Sills, Cohan and Stein 2006). Labouvie-Vief (2003) attempts to explain resilience in terms of individual differences – why some people grow from difficult experiences and others tend to break down. Different types of people were characterised by high or low levels of optimisation or differentiation. "Positive self and emotional development is measured by optimisation of happiness but the second aspect - the ability to tolerate tensions and negativity in the interests of maintaining objective representations – needs to be integrated within this hedonistic emphasis." (Labouie -Vief 2003:3). She concludes that the integration of these two aspects – optimisation and differentiation reflects a dynamic balance. She also contends that significant growth in affective complexity occurs through middle adulthood suggesting the need to optimise the potential for this time of growth in mature students.

Other personal strengths have been equated with resilience such as a positive self image, hardiness, optimism, a sense of humour, a belief system which provides existential meaning and hope (Tusaie and Dyer 2004), a sense of self efficacy (the individual's belief in their ability to control events in their lives) and self understanding. (Hammond 2004). These all form part of a wide range of active coping strategies and social skills enabling resilient individuals to assess a situation, understand its various dimensions, do what they can to intervene in a helpful way, and importantly, have the capacity to let go of things that they can do nothing about and move on (Kahn 2005). Environmental factors are also influential

and relate to perceptions of social support– a sense of feeling ‘connected’ whether to family, peers or colleagues. It is suggested that an individual with a negative view of the support offered may ignore or repel it and therefore receive less, suggesting that an individual “is not a passive recipient of social support but the process of social support is reciprocal and dynamic.” (Tusaie and Dyer 2004:4)

Richardson’s et al (1990) model of biopsychospiritual homeostasis might be useful in focusing on the processes involved in acquiring resilience and in deciding how best to help individuals gain strength. The belief underpinning the model is that stress and situations which are challenging in life have the potential for growth but can also lead to hurt, loss, guilt, fear, perplexity, confusion, bewilderment, and self-doubt (Richardson 2002). Resilience therefore infers more than simple recovery, but positive adaptation or growth, following a period of homeostatic disruption (Campbell-Sills, Cohan and Stein 2006) and it opens up the key research question about what interventions or adaptations can be made in the immediate environments to enable positive adaptation rather than negative reaction. This adaptation is a process which occurs throughout our lives and is necessary for our survival – emotionally, educationally, and socially. Richardson’s model explains how following disruption of homeostasis, there may be conscious or unconscious reintegration resulting in one of four outcomes:

- resilient reintegration which results in positive growth, self understanding and increases the likelihood of resilience in future;
- reintegration back to homeostasis,
- reintegration with loss
- dysfunctional reintegration.

An important question can be raised concerning the helpfulness of the model in pointing us to training or support strategies which could enhance the development of resilience. In order to ensure positive growth, Wilkes (2002) argues that we need to achieve a level of skills as critical thinkers for our own emotional reactions, in other words applying the same kind of critical analysis to ourselves as we apply to academic work. Becoming more aware and analytical about their emotional reactions to situations could help students not only to regain equilibrium but to recognise inappropriate or unhelpful reactions. It may also affect the strategies they use since an increase in self awareness can not only help an individual to make a more rational judgement of their capabilities but if they feel any criticism unjustified seek constructive dialogue (Abraham 2004)

Wicks (2006) suggests that health care professionals have the potential for developing secondary stress as a result of the pressure of their daily requirement to reach out to others in need but questions the extent to which they learn to appreciate, minimise and learn from their reactions. Jackson, Firtko and Edenborough (2007) see this as part of ‘workplace adversity’ and the reason that many nurses leave the healthcare system or stay but experience stress or burn-out, a progressive loss of idealism, energy and purpose. However they also note that, in contrast, other nurses seem to thrive in spite of very demanding and challenging situations showing that they are able to “ride out the inevitable points of stress that threaten to destabilise them and their work (Kahn 2005:36).” The reasons for the differences are not clear but understanding why some are able to do so is important professionally since, as well as the personal effects of stress on self-image and confidence, there are consequences for organisations as one person’s stress can induce stress in others, described by Wicks (2006) as ‘burnout contagion’ which decreases efficiency.

Other studies have considered organisational and professional implications. Abraham (2004) describes emotional resilience as ‘flexible optimism’ so that, instead of engaging in

fault-finding, individuals are flexibly optimistic enough to put difficulties behind them and redirect their attention to positive means of coping. Resilient individuals have emotional self control and are able to judge emotional cues from others, modify own responses and avoid dismissive or aggressive responses. These are all at the core of many important practice skills such as those needed in negotiation for resources and dealing with difficult situations such as defusing situations with angry service users. In addition, according to Abraham (2004) self- control and emotional resilience delay the onset of a decline in performance from excessive job demands and can both promote superior performance, if positive feedback is given in an informative way, and can also mitigate the effects of negative feedback.

Although emotions and aspects relevant to resilience such as hardiness, self efficacy, locus of control have also been studied over a long period of time, the emergence of Emotional Intelligence (EI) over the last two decades has generated renewed interest in the effects of emotion on rational thinking and behaviour both at a social and professional level (Freshwater and Stickley 2003) although it is not without its critics in the way it is both defined and measured(McWilliam and Hatcher 2004). EI is defined as the ability to use emotional information and integrate it with thoughts and actions (Slaski 2002) and thus Goleman (1996) claims that those with higher EI are more successful at work and in their personal lives because they are more self aware and are able to use emotional experiences to better manage relationships and guide their behaviour. This view is reflected within the increasing recognition of the importance of the value of 'emotional capital' in business management. Gendron (2004) defines this as a set of emotional competencies within individuals which are useful for personal, professional and also for organisational development. She argues that these competencies need to be recognised, valued, nurtured and developed as they are vital for social and economic success and therefore asserts that emotional capital must be taken into account seriously by policy-makers, practitioners and business organisations.

Mc Queen (2004) argues for more recognition of the emotional work which nurses undertake and for a consideration of possible links between emotional intelligence and emotional labour and its impact on both carers and those being cared for. She suggests that a balance is required 'to provide intimate, personal attention to patients whilst recognising personal limitations and engaging in coping mechanisms to protect oneself from burnout (p 105).' Following a systematic review of the literature related to resilience as a strategy for surviving and thriving in workplace adversity, Jackson, Firtko and Edenborough (2007) suggest the following components should be the focus for self- development for nurses ; the building up of positive nurturing professional relationships and networks, the maintenance of positivity, the development of emotional insight, the achievement of a life balance and spirituality and the need for increased ability to be reflective. They define emotional resilience as the 'ability of an individual to adjust to adversity, maintain equilibrium, retain some sense of control over their environment and continue to move on in a positive manner (p.103).'

Fenton O'Creavy, Nicholson, Soane and Willman (2003) studied traders to understand how they respond and adapt to taking risks in financial markets which may result in huge losses or gains. Although the context of international stock markets may seem to be a long way away from health and social care practice, certain parallels may be drawn. Like health and social care practitioners, traders require the ability to engage in quick and concentrated analysis of situations and to influence others. They need certain qualities of character to withstand stress, hold their nerve and make calm judgements. Through the experience of working with experienced colleagues and entering into the social interactional process within a community of practice (Wenger 1998) they learn the 'theories of how to work the

world'. Fenton et al noted the effect emotions had on memory functioning with negative experiences tending to be more easily recalled than positive ones. At first emotional reactions to loss and gain were greater for novice traders than more experienced ones and they needed help, through the analysis of critical incidents, to rebuild their confidence if they experienced losses to make them "battle-hardened enough to cope with the experience." In addition, those who enjoyed their role were highly motivated with a sense of personal effectiveness and found it easier to cope with their emotional responses. This has implications for the importance of providing particular support for novices and for creating a safe culture where individuals feel valued and able to express their feelings and analyse them under supportive supervision. Suitable forms of assessment and guidance are necessary if we are to enable individuals to become more aware of their thinking and behaviour patterns and strategies need to be devised which are most effective in helping them to recognise these and learn from them.

All this reinforces a need to review current educational strategies and the resources needed for students for the development and the growth of personal strengths and effective ways of responding. There are benefits therefore both personal and organisational, for building up emotional resilience in individuals from the moment they enter the profession.

3. Methodology

The literature reviewed focused predominantly on individual characteristics, individual strategies for coping and the impact of immediate social and environmental factors so can be broadly classified as psycho-social in approach. The work by Fenton O'Creavy, Nicholson, Soane and Willman (2003) went a little further towards the development of a social model but for the purposes of the initial construction of research questions the definition arrived at by Jackson, Firtko and Edenborough (2007:3) will be used as a working definition:

the ability of an individual to adjust to adversity, maintain equilibrium, retain some sense of control over their environment and continue to move on in a positive manner.

The research questions are then defined as follows:

- What does 'adversity' mean for Pre-registration Nursing students
- What characterises resilient individuals?
- What survival tactics do they use?
- How can we promote the development of resilience by the nature of the academic and practice support we give students and the kind of learning which accompanies this?

Because of the nature of the research questions, a qualitative approach was used to determine sample, data generation and analytical and interpretive decisions. Initially data was gathered from a focus group interview (see Appendix 1) and this was used to generate initial issues and questions and to determine a broad framework for individual interviews. Eleven in depth interviews were then recorded, transcribed and analysed through categorisation of key themes. After each interview emergent dimensions were identified and these influenced the focus of subsequent interviews.

4. The nature of student 'adversity'

Participants in the study indicated some of the stresses they faced and these are summarised in table 1. The data parallel findings from other studies which describe the effect of heavy workloads, academic pressures, financial constraints, and the emotional nature of practice (Timmins and Kaliszer 2002). In this study there was also evidence of the impact of factors participants perceived to be standing in the way of 'perfect' practice and consequently of what Glasberg, Eriksson and Norberg (2007) described as the 'troubled conscience' all health care workers can have when they feel they cannot provide the good care they would wish to give. Some experienced stereotyping and prejudice related to age and thought that there were higher expectations of them from their clinical colleagues because of their past experiences as healthcare assistants, although relationships with clinical colleagues were generally good and supportive.

All described a combination of public and private emotional labour, particularly as they identified with, and cared for, dying patients and engaged in challenging situations which caused ethical tensions and dilemmas.

Getting close to people - I think that's something that I need to learn to deal with - I know it's not a bad thing but I don't think it's a good thing either and I think there's a fine balance between the two... You can't care for somebody without caring about them, I suppose that's what I'm trying to say ...(Int. 6).

Knowing when to intervene and when to stand back also caused tension:-

I visited a gentleman who had a bed salesman arrive. And this gentleman was depressed and I knew that this bed salesman would want to sell him this bed because he'd got this physical problem...(Int. 1).

Most participants in this small study, including two male participants, found juggling home life with academic and practice pressures difficult particularly since they also took on the responsibility of being the main carer for a sick or disabled relative.

My father in law's been in and out of hospital so when everything's running smoothly that way and on an even keel it's fine, but it's just if he takes poorly or ...it's just the worry around it then isn't it? But I know I'm my own worst enemy because I have to start saying no, but it's very difficult. (Int. 6).

This reinforces findings of a study by Phillips, Bernard and Chittenden (2002) who, although they focused only on the impact on women working as formal carers, came to the conclusion that being a nurse or a social worker might mean that other members of the family delegated the responsibility of care to them.

5. Developing emotional resilience

Four themes emerged from the study related to individual characteristics and strategies which promote resilience. These were:-

- Ways of being
- Personal survival tactics
- Immediate social environment
- Wider social and cultural environment

These key themes can be conceptualised as interacting in the manner outlined in Diagram 1 below. The interaction of the key themes is set against the backdrop of *experience* and *engagement* in recognition of the impact of past experiences and future processes of engagement on resilience.

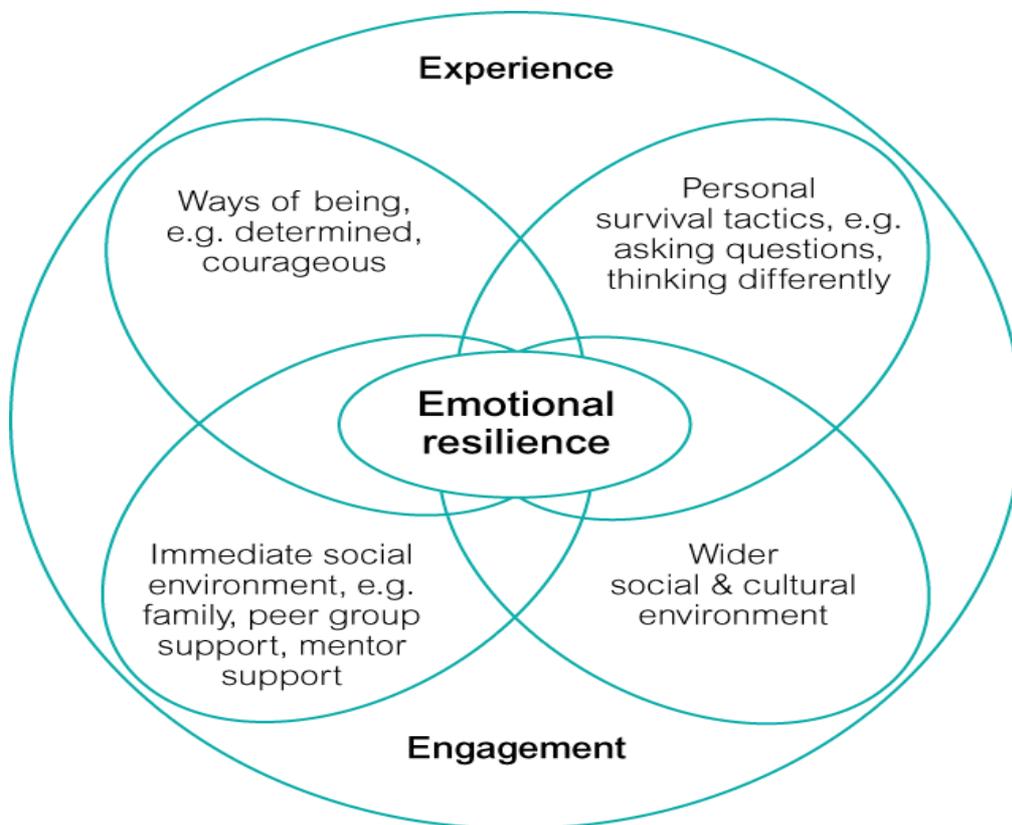


Diagram 1: Key themes identified in the development of emotional resilience

Ways of being

These mature students brought with them life and work experiences which stood them in good stead as a way of responding to the demands of the work. They indicated that they had gained a great deal of benefit from learning to be reflective which had increased their self awareness. Ways of 'being' which helped them to cope related to personality characteristics such as being positive, open-minded and having a sense of humour, and also being what they described as 'pushy':

Stabbing someone with a needle was not something I looked forward to. I felt very nervous before and once we did the theory I just said to all the staff 'Any injections – it's not because I want to do them or like to do them but just flood me with them. I want to get rid of that fear!' Which is what I did. (Int.2).

Data uncovered high levels of determination and motivation:

It is hard, yes it is hard to be focused, it is hard, there's times when you just want to sit down and scream or cry and or both sometimes, but I've got to be - I've got so far and I'm not letting it go now...I would never forgive myself if I let it go now, I'll never forgive myself. (Int. 5).

Keeping focused on the 'final target' helped:

I think it was the passion of becoming a staff nurse, of becoming a patient's advocate because that's what I've always wanted to do. And I did not feel I could do it as an auxiliary nurse because you don't get listened to as you do as a qualified nurse. So that passion has kept me going and if it hadn't been for that I think I would have struggled, definitely (Int.11).

Links between their epistemological and the ontological development were seen in examples of how they used academic learning e.g. concerning the nature and process of grieving to try and understanding their feelings:

When the exam result came through I wanted to pick it up and throw it against the wall. I can't cope with this and everything else that's going on, I just can't cope with it all!...But you go through different feelings I suppose, it's like, it's like losing somebody. You go through your crying, you go through your anger, different stages, yes, yes, like a grieving process I think, that's what I went through.(Int.5).

The ability to 'pick yourself up' and reflect back on stressful periods was vital:

I just totally stressed out - just couldn't stop crying but I'm alright now.....I was on leave afterwards so I didn't really take any sick time, I had leave and I just came back down from that. I didn't touch any course work for about 3 or 4 weeks, I couldn't look at it basically because I'd just done too much. I think I overdid it basically but I'm all right now. (Int.2).

The theme of ways of 'being' revealed many personality characteristics in common with those identified in the literature review e.g. in terms of self-awareness, determination and motivation. Becoming a student led to a more positive view of themselves as they progressed and achieved success but this was countered by negative views of self-efficacy if they felt unable to control situations and overwhelmed by academic and practice requirements.

Personal survival tactics

In this theme a range of strategies were identified, which helped participants to retain emotional balance and help their personal and professional development. For example, they showed the ability to adapt and restructure their thinking in order to engage with and reframe the problems they encountered and also to be assertive and use tact and diplomacy in their negotiations with others.

It is good to be a member of the team but sometimes you need to step out of that and think well actually I need to learn about this.... I've got this opportunity- I need to do that now because I will not get that opportunity again. (Int. 10).

I do think there are skills of diplomacy. If somebody's rude to you and you're quite rude back, it's not really going to help the situation I think you've got to be firm in what you have to do but then be quite sociable, not hold it against them. (Int. 3).

The recognition that learning is involves an active 'two-way process' was evident:

If you get where you're attentive really when you're on placements and you're actually asking questions and you're interested and you can show your rationale of what's happening then I think your mentors give you more which is good. That's been my experience anyway. (Int.8).

I've decided that it's down to me to make things happen so I've just really tagged along with the staff nurse and said 'Can you show me how this is? and I've learnt a lot from that I've got to get the most out of that and it's down to me. (Int. 3).

I don't know whether I've just been lucky or whether it's a bit of a two way responsibility really but you have to put yourself forward and ask. (Int. 6).

There were issues related to role identification and expectations, and students had to find ways of dealing with these:

You've worked as a healthcare assistant and then you're a student and you think people expect more of you than they would of a student coming in fresh.... that has it's advantages and disadvantages because they sort of expect that you can do more and you can. (Int.2).

However, high expectations could lead to a feelings inadequacy although the ability to 'stand your ground' helped overcome these:

*And I said 'I've never had anything to do with chest drains'. So she said 'Oh well, what **can** you do?'... I'd never even seen them. I'd heard about them but I'd never seen one or dealt with one and it was really scary.... And I said 'Well I'm here to learn, I said what's the point in sending me somewhere where I know it all? That's what I'm here to do.' (Int.4).*

Some gave a clear reminder to clinical colleagues to avoid ambiguity:

I went into the multi- disciplinary team which I am a part member of it and said I am a student, I'm here in a student role. So it was important to get the team to recognise me as something other than a support worker. (Int. 1).

There was evidence of personal cognitive restructuring related to role:

You've got to come out of that auxiliary mode and change to more of a nursing mode. Because it's quite easy to slip back in thinking you just continue as you always have. Then you are sort of telling them there's this problem and expecting them to sort it out when really you really need to be thinking about what you would do about You're more of a thinker planner than a doer. (Int. 10).

In addition, a negative event could be turned into a positive one by for example seeing a problem as a learning opportunity. This was achieved through self reflection or by being helped by others, particularly peers or mentors.

Is it failure? I think it's just now logically thinking, it's a blip that I need to get over. (Int 5).

It may also mean realising that there is no 'perfect way':

The one thing I've found difficult within the assessment, is asking people if they've got any plans sort of to take their own life - to get the wording right. The first time I made a complete and utter mess of it and I know I did... so I spent quite a lot of time, my mentor gave me loads of stuff about it, you know, to read as well as class work. And he said you will find your own wording - you have to find your own wording. He has his, and others find, a different way of putting things. (Int. 1).

All the participants acknowledged the benefits of learning to be reflective as part of their academic study although some found the need to keep their own personal journal which was not utilized in the more formally scrutinised assessment process. Keeping a personal reflective journal, for example, helped one student to be honest in articulating her feelings and contrast changes in perceptions

I was so stressed, I kept a diary every day, a daily one and when I looked at it after-.I was there 8 weeks I think- yes. I looked back and thought I've learnt loads ...and my last day I said oh I'm sorry to leave this placement it's a shame I can't stay longer and I looked at what I'd written on the first day, it said - I don't want to be here any more. (Int. 4).

Responsibilities and pressures related to home, academic work and study required organisational skills and the maintenance of clear parameters:

My children are older so if ironing doesn't get done at home or it's beans on toast, that type of thing, they just have to get on with it. .. I don't know how I'd manage if I had little ones. I can shut myself away and I say this is study time and they all understand that (Int. 6)

This also meant that they had to 'shut off' one area of life from another:-

I mean I've got a lot of problems at home and what have you, but I have to put that to one side because you can't take that into work..... Sometimes it's really hard to shut off it's like putting the shutters down, you have to do it. (Int. 4).

So then it was a case of right you've walked out the door, as long as you've done the best of your ability whilst you've been there and you've treated everybody in the way that you would want to be treated, what more can you do? (Int. 2).

The various personal survival strategies (outlined in Table 2) suggest the ways in which participants used a range of methods to tolerate and learn from tensions which were the result of both academic and practice demands. Although there is some evidence that these experiences may have led to adaptation and growth (the resilient reintegration stage of Richardson's et al (1990) model) it was also obvious that these experiences could lead to fears and self-doubt. Supportive networks helped them to overcome these.

Support provided by the immediate work, social and educational environment

Students perceived peer support as the most important supportive aspect, vital to enable them to meet academic challenges and helping them to gain emotional support and advice concerning 'little quirks' about various practice environments . Peers were 'the first point of call' if they had difficulties. They also worked hard emotionally in providing support for their

peers and all had created their own support networks and had become 'very close' to each other.

We've become very close over the last 2 years and we are very very fortunate.... We really don't know what we'd do without each other... If one's down somebody's usually up and you try and find a balance don't you, with all the different personalities within the group (Int. 6).

It saves throwing yourself out of the window. You get to a point and you think I can't do this ...it's a nice feeling to know you're not alone ... everyone's in the same boat and that's very helpful (Int. 9).

It's an immense help - the fact that you were going through it together, not on your own because I think if you are a student you're out on a limb... Without that support and being able to meet together, I think we would have probably floundered or really struggled and not done as well. (Int.10).

Families played a part in keeping their 'feet on the ground.' To do this they had to be able to set clear boundaries between home and work and for 'taking time out'. One student attributed a particularly stressful time to a period where she had neglected 'her family and social life'. Partners could help to 'get things in proportion'.

I actually went downstairs and said to my husband, 'I don't want to be a doctor, I'm not doing a Masters, look at this'. And he said X, it's just a chapter, get you head round it - it's a chapter. You've got to understand about the make up of cells, that's all they want you to understand. (Int 8).

Examples of ways in which mentors, programme tutors and tutors provided effective support were also identified:

There have been times when I've just felt is this all worth it? What am I doing? Just once I got myself so upset that I phoned my mentor... She said 'I'll send you an E mail and ring back later. I want you to just read what I've got to say to you first.' And it was all about how far I'd come, her confidence in me ...And you just think wow, if she's got that trust in me! And from then on I've been able to pick myself up...And then she phoned me, it was a couple of days later and she said have you read your emails? and I said yes thank you very much. She said are you alright? She said let's meet for a coffee and we did and we were fine. She said if you're ever feeling like that, don't let it get you down -you know you can always call. (Int. 8)

This reinforces work by Bradbury-Jones, Sambrook and Irvine (2007) who suggest that mentors can play an important role in fostering empowerment in student nurses which brings with it enhanced self-esteem, motivation and positive attitudes.

Participants in this study identified that it was the quality of the mentorship which was important, not necessarily the amount of time spent with them. It was helpful to have a mentor who 'understands what is required' and not one who us 'unclear what they are taking on' which may mean that 'you have to struggle on by yourself' (Focus Group Int).

The Programme Tutor could also help clarify and explain by using familiar language:

The portfolio changed quite drastically and also the level of study changed a bit as well, in the way of writing. It became very different, it was more analytical more critical... And all of a sudden it just felt like we've gone from the first step to the tenth

step in one go, and you know it's a long way down. . We've had a really good Programme Tutor and she's been marvelous, absolutely marvelous, and without her I don't know what we would have done.....I think she understood us, I think she understood the programme really well and she interpreted it, so that it felt like it was in plain English. I think she was more on a level with us. (Int 11)

This can be explained by the concept of inter-subjectivity or 'meaning making' between two or more people. Northedge develops this idea to explore how teacher-student inter-subjectivity is critical in bridging the gap between everyday ways of thinking and academic discourses (Northedge 2003). The difference between this Programme Tutor and the previous one was that she was able to 'interpret' the academic discourse and thereby create a way for students to engage and participate within this discourse.

This participant also found the way in which her Programme Tutor also took into account clinical demands helped her mentor to maintain a positive approach to her mentorship:

She understood that our mentors did not have the time to come in, sit in a meeting for an hour to discuss our progress, it just wasn't practical. So rather than that, she'd ring them up, and say 'How do you think she's doing? Then she would try and arrange sort of ten, twenty minutes where we would just do the most important bit. And we have done a lot of preparation before the meeting.... Yes it was there ready and we could discuss what we needed to discuss and then the mentor could get back out on the ward... (Int 11)

However, even if support from others such as Programme Tutors is available, students may see asking for help as an indication of inadequacy:

I do ring the programme tutor, I have rung her on a few occasions and I have emailed her as well, but I think it's partly my own fault because I just get on with it. I try and get on with it so I should really use the network that's out there, shouldn't I? I think it's probably the - the feeling of inadequacy I should think, you know not being able to do it... Yes it's me, I just need to swallow my pride and go and get some help. (Int. 7).

Findings confirm the literature on emotional resilience which claims that others play an important part in supporting a person's strengths and moving them towards functional coping. In this study, participants were not passive recipients of that support but had to seek it out. This may have been why, although others, particularly mentors, provided helpful often vital support, their peers, with whom they shared common emotions, problems and felt 'connected' played such a crucial role. This was a reciprocal relationship in that they not only received emotional support from their peers but provided it as well.

Wider social and cultural dimensions

Some of the issues discussed so far have touched on structural factors such as gender and age, aspects of the culture of workplace learning, issues related to identity and ideas about caring and being a professional.

Gender

Out of the eleven students interviewed, two were male. Clearly this is not a sufficient sample to make sweeping statements about different challenges for men and women within the context of a pre-registration nursing programme. However, the focus group interview provided some evidence that nursing practice is constructed as a gendered activity.

Students generally had to be quite assertive in getting their student identity to be recognised and for the men there were additional challenges related to gendered assumptions. For example, there was a lack of explicit advice in terms of what could and could not be done in relation to intimate support.

What I've had to overcome is being a male nurse. There's a difference between what you can and can't do. There's been no guidance so if there was some sort of advice in some reading somewhere that would be helpful. (Focus Group Int.).

There was also some indication that there were more issues for men in asking for help and drawing on support networks that could impact on the development of resilience but further research would need to be done to make any comparisons based on gender.

Age

Age was also a recurrent theme and stereotypes drew on cultures of workplace and broader societal ideas about age, status and learning.

I get a lot of people saying to me when I go on placements 'ooh what do you want to do nursing at your age for, aren't you too old'. (Int.4).

I've been out with a staff nurse and the patient has looked at me for the answer and I say, 'I'm sorry but you need to be talking to..' and you feel awfully stupid sometimes at that stage but.. and asking somebody so much younger than yourself – 'what exactly are you doing that for?' (Focus Group Int.)

Both extracts relate to the fact that the Open University's Pre-Registration Nursing Programme is a work based programme and the average student age is higher than on other programmes. Students also have an ambivalent position as both health care assistant and student and there is evidence here that the juxtaposition of age and student identity is in conflict with broader societal ideas equating youth and formal learning or 'apprenticeship', despite the current emphasis on life-long learning.

Ideas about care and being a professional

Students on the pre-registration nursing programme articulated ambiguities in relation becoming qualified practitioners.

As a nursing student I've got the time haven't I... As a qualified, that's what's worrying me, I don't want to lose that direct contact with the patients [] When I'm doing assessments I like to make sure that I've got time to spend with them, there's no other distractions. You can find out a lot of what people really need if you can build that relationship between you and the patient. If you get close to them to a certain extent, they are willing to tell you things that otherwise they wouldn't. [] Trust, I felt the trust in the relationship that he was able to trust me to do his leg dressing, and afterwards he said 'oh you can do that again'.

This was a recurrent theme. If this theme is explored from a discourse perspective it gives insights into the broader system of meaning that shapes ideas about both caring and being a professional. It also highlights that identity can be understood in a more active way – not constituted by fixed characteristics but a process that involves some degree of choice. In this instance the choice is how students position themselves within caring discourses. Clouder (2005) explores caring as a 'threshold concept' in that it exposes students to new ways of thinking about care in a professional context,

The opening up of previously unknown alternative ways of viewing caring in a professional context can lead students to question fundamental beliefs and values, creating uncertainty and doubt. (Clouder 2005).

Arguably, it isn't that these ways of viewing caring are previously unknown but that they are brought into sharp relief when they impact directly on personal identity. In the extract above, being a Healthcare Assistant or student is equated with direct patient contact whereas, by implication, being 'a qualified' implies a more remote role. Input is equated explicitly to time but the narrative also reveals a 'use of self' or 'discursive practices'¹ that involve emotional involvement, empathy, interaction and building trust that are perceived as inappropriate within a more professional role. This student clearly has worries that taking on a professional identity will mean being more emotionally remote and distant from the patient experience.

Key findings and implications

Students on professional programmes have many demands which are often competing and may affect their ability to engage in and develop their academic as well as practice based learning. There may be a double burden of societal expectations of them as carers. Although they brought with them many life and work - based skills which enabled them to cope with many of the demands placed on them and had clear focus on the ultimate goal, they used and developed personal skills which enabled them to retain emotional balance such as increased self awareness through reflection and utilisation of academic knowledge to explain and understand emotions. These findings therefore supported Tusaie and Dyer's (2004:3) definition of emotional resilience as 'a combination of abilities and characteristics that interact dynamically and allow an individual to bounce back, cope successfully and function above the norm in spite of significant stress or adversity'. However, in addition to these, the support offered by their immediate work, social and educational environment was vital to participants, both in terms of direct face to face support and guidance but also in retaining a positive self-concept.

In this study, participants valued peer support highly and saw this as critical to their success. Peers shared common experiences which helped to overcome self-doubt and there was a sense of solidarity, concern for each other and a group identity. Peers spoke 'the same language' so they could help each other by explaining academic work within a known discourse, thus 'reframing' the unfamiliar. Programme Tutors and mentors also had a key role in 'interpreting'. However, peer relationships were balanced in terms of power and were easily accessible and these characteristics were a powerful influence on the way learning, both in practice and academic study, was experienced and evaluated. Because of their influence and potential benefits, it would seem appropriate to take peer support networks more into account within programmes of study and give further consideration as to how these might be developed and supported. Some authors (such as Stewart, Mort and McVeigh 2001) suggest that peer learning partnerships should be formalised very early on in academic programmes.

The study uncovered examples of good practice by mentors and tutors which could be usefully shared as part of professional development. The importance of positive feedback and the role of all those supporting student learning in reframing problems cannot be underestimated. A sense of working in partnership with mentors and academic staff was

¹ The ideas of 'discourse' and 'discursive practices' are drawn from Foucault's broader framework for examining the relationships between power, knowledge and discourse (see Rabinow, 1984)

empowering for students and helped to keep them motivated, whereas feelings of failure or inadequacy led to self doubt. Effective reflection helped students to be self-critical but positive but some also needed to undertake this outside an academic discourse.

In the literature review the interrelationship between key notions of 'emotional labour' 'emotional intelligence' and 'emotional capital' also emerged. Understanding the application and implications of these terms for students and professionals who support them, may help to value their significance in terms of the contribution emotions can make both in fostering personal development and care for others. Although there is some evidence that mature students are more likely to self-refer to academic staff or University resources than others if they have problems or concerns (Stewart et al 2001), there was still a tendency for participants in this study to see it an indication of weakness. This may have been why they chose peers as their first port of call.

An exploration of broader social and cultural factors pointed towards factors such as age and gender being implicated in the processes of development of emotional resilience. Class, wasn't specifically addressed but there is a correlation between level of previous educational qualifications and socio-economic group. Students on the Open University's Pre-registration Programme typically include approximately 72% who would not meet the standard entrance criteria for entrance to University (although all must meet the NMC requirement for entry to a qualifying nursing route). Lack of confidence and self-esteem typifies students in this 'widening participation' group and therefore factors acting against resilience such as self doubt can be seen as socially structured rather than just an individual attribute. Again, this reinforces the key finding that peer support is particularly important for nursing students.

The interaction of discourses related to 'being a carer' and 'being a professional' raised areas of concerns. If individuals take on the role of Health Care Assistant because of the intrinsic satisfaction of 'care-giving', then perceptions of a professional role that is more remote and less engaged with patients is likely to create ambivalence about the ultimate goal and therefore impact negatively on their motivation to keep going. It also raises questions about the patient experience if qualified status brings with it discursive practices that produce overly rigid boundaries between what is constructed as professional and lesser status care work.

Summary of the main findings/implications:

- The critical importance of acknowledging and facilitating peer support.
- The importance of positive feedback and of enhancing the student's ability to re-frame difficulties or problems.
- Ensuring a culture of learning where students are accepted, given opportunities and where resilience is fostered. .
- Recognising the importance of valuing, utilising and nurturing emotional capital.
- The recognition of supporting and validating personal reflection which is outside an academic discourse.
- The recognition that students need support in 'interpreting' academic discourses to make them meaningful
- The importance of identifying good practice by mentors, programme tutors and tutors and of sharing those findings.

It is concluded that these findings have implications in terms of pointing to various ways in which students might be helped to increase their resilience. These include consideration of the nature of the content and resources used for mentor and tutor development and of structures that facilitate peer interaction and support and validate personal reflection.

6. Developing the definition and building a conceptual framework

The analysis of the transcripts, using the working definition, has given a lot of insight into both the challenges and range of coping strategies students have utilised to develop emotional resilience and ride the waves of the ups and downs of being a student on the Open University's Pre-registration Nursing programme. It has also led to specific recommendations that would have a direct impact on the curriculum, pedagogy and student support structures.

However, the analysis has stretched the initial definition of resilience as a specific ability or characteristic of an individual. This was a useful tool for setting the framework of the enquiry but analysis of the transcripts has opened up broader questions of 'meaning making', discourse and related practices, or discursive practices, that imply the need for broader framework(s) of analysis and a more integrated concept of resilience.

The investigation is based on a Pre-Registration Nursing Programme, so learning is part and parcel of being on that programme. The original definition of emotional resilience, however, includes a sense of adjustment and moving on in a positive manner that implies a more general openness to ongoing learning in the face of disruption, challenge or ongoing change. This was also reflected in the transcripts.

At the beginning of the course I thought oh yes, you know. I know what I'm doing but I didn't realise how....well I knew how little I knew, because I think even as a registered practitioner you only ever know a tiny amount and you are learning all the time and when people said it's about a constant learning curve, I thought oh yeh once you've finished it that will be it but reading the course has made me realise you know, yeh, you've got to continue on learning until the day you retire and probably after that. (Int. 1).

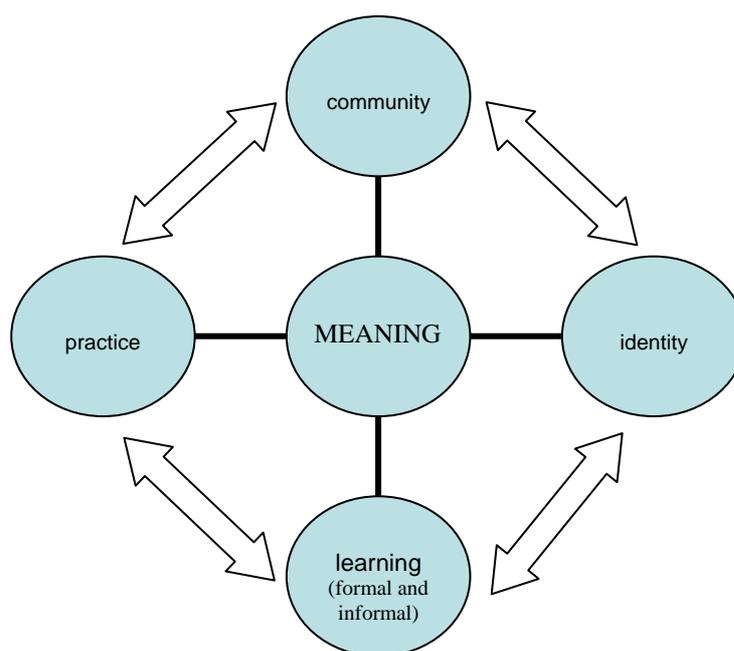
What has also come across strongly in the transcripts is that learning and associated development of resilience takes place through the active engagement and participation of students within the actual situated context of nursing practice. This raises the question that it might be useful to also explore a socio-cultural perspective that places the focus on the practice context in which the individual is situated and discourses, practices and negotiation of identities that operate within that practice context, rather than looking at individual differences per se.

Lave and Wenger's notion of 'situated learning' is a useful starting point (Lave and Wenger, 1991). This relates to a social theory of learning where learning is at the centre of our lived experience and participation in the world. As such, 'informal learning' that occurs in engagement in practice is privileged as a site of analysis rather than 'formal academic learning'. Wenger later developed the idea of an organisation as a number of 'communities of practice' and focused on the inter-relationship between community, practice, meaning and identity as key components of engagement and learning (Wenger, 1998). Wenger does not explicitly address emotional resilience but the framework he uses would lend itself to a definition of resilience that places more emphasis on specific organisational structures and configurations that promote vibrant and active communities of practice and provide opportunities for 'legitimate peripheral participation'² for novice practitioners in those

² Legitimate peripheral participation is defined by Wenger as the process by which newcomers become included in a community of practice (Wenger, 1998:100)

communities, with signposted routes in to full participation and engagement. This shifts the emphasis from individual attributes and coping strategies to organisational structures. In the adapted diagram below learning is conceptualised as both 'engagement in practice' and 'academic' learning. Meaning is positioned as a central component of learning and Wenger describes this as 'our (changing) ability - individually and collectively - to experience the world and our engagement with it as meaningful' (Wenger 1998:4). From this perspective, structures that foster meaningful participation could be said to promote individual, collective and organisational resilience.

Diagram 2



Adapted diagram of components of a social theory of learning (Wenger 1998:5)

If the above diagram is applied to this specific project, learning is defined as both the everyday leaning that occurs in a (nursing) practice context and the more formal learning that occurs via the structured learning materials and pedagogical support provided by the Pre-Registration Nursing Programme. As stated previously, Wenger privileges the former but arguably more formal learning also takes place within its own community of practice or knowledge community (Northedge, 2002), that has its own repertoire of methods for fostering participation and its own discursive practices (participating in face to face and on line tuition, writing assignments, complying with academic conventions such structuring a piece of work, developing arguments, using evidence, referencing).

Applying the diagram illustrates and gives more insight and understanding into some of the challenges facing the student nurses. They have to find a way of actively engaging in a meaningful way in both a professional community of practice and a knowledge community

of practice and somehow integrate both of them. They have the additional challenge of being 'novices' within both communities and there are therefore barriers to full engagement and participation. They also have to struggle to negotiate and assert identities in both contexts – within their practice context they are both student nurses and employees as Health Care Assistants and within an academic context they bring their practice identity with them.

Identity

The transcripts have numerous examples of how students have to actively negotiate different identities within a practice context.

- I. And do you think people treat you differently than they would other students*
S. Yes, I find it difficult getting people to treat me as a student
I. What do they treat you as?
S. They treat me as me.
I. As an experienced healthcare..
S. Yes, they treat me as me and again they don't sometimes treat me as me, as a student
I. The other healthcare assistants don't see you differently when you're a student
S. No, they do see me differently but they still treat me as me
I. As you
S. It's always nice to be treated as me, but sometimes it's really difficult too
(from Int.7.)

This illustrates some of the difficulties and tensions of taking on a new identity within a community of practice. As Wenger says, 'it is not easy to become a radically new person in a community of practice..our identities become anchored in each other and what we do together [] it is not easy to transform oneself without the support of a community' (Wenger 1998:89). The students in the study were very proactive in seeking support and developing strategies to make sure they got the opportunities they needed but there were also barriers. Identities in a community of practice are not neutral, they are closely interwoven with hierarchies of status and power. The Health Care Assistant who is also a student occupies an ambiguous space both in terms of status and extent of legitimate participation and there were examples given of 'blocking' activities such as restricting the range of activities students were involved in to more menial tasks.

Practice

The extent of legitimacy was around both higher expectations of what these nursing students could undertake in a practice context or reducing levels of responsibility when they were in student role. One student describes her frustrations at not being able to engage sufficiently in practice,

We had a lady come in....now she came in with pressure area damage to both heels and because they weren't dealing with that specifically, they were dealing with breast care operations, this was ignored to some extent and part of my community work is doing dressings, feet and I could smell this wound and nobody wanted to seem to do anything about it and I was really....you know it's embarrassing for her because this awful smell, the bed was wet where it was leaking which wasn't nice for her ...but because of the way that the ward works I couldn't go and do it and I was desperate,

nobody's doing anything about this dressing, please somebody just go and clean it!!! And it didn't matter how many times I seemed to mention it, 'oh yeah we'll get round to it, we'll get round to it' and I found that very frustrating.[] The holistic care which we go through all the time, you know it's not just this bit or this bit of it, it's the whole person was being ignored. This lady's dignity because of the smell...it's a 4 bed bay and you could smell it and they weren't doing anything. (Int 9).

This extract also illustrates the challenges that these student nurses can bring to existing practices because of both the previous practice and life experience they bring to the role and the formal learning they are engaged in. There is other evidence that life experience enables individuals to have very clear views about professional nursing practice that in many ways challenges the notion of a professional role as more remote and 'rational'.

you bring your own life skills into this course and being that little bit older, and just....I think you can relate more to people, to patients, and you understand the wider aspects, it's not just such and such in bed 4, it's not as simple as that [] Well obviously knowledge comes into it but I think if you haven't got other skills, like interpersonal skills, if you haven't got those people don't feel they can warm to you and trust you with information that they are giving you.(Int.8).

Induction into an existing community of practice is therefore likely to be a less smooth transition for the more mature and experienced 'novice' than for a younger person who has not had the same level of previous engagement. There is evidence to support the view that these student nurses are much more likely to challenge existing discourses and discursive practices related to professionalism.

Learning

Students frequently expressed difficulties in fully engaging within academic discourses, 'the biggest problem I have is with the academic side of thing'. The more distanced the areas of knowledge were perceived from direct practice the greater the difficulty in meaningful engagement or as Wenger says, 'information itself removed from forms of participation is not knowledge, it can actually be disempowering, overwhelming and alienating' (Wenger, 1998:220)

..as far as biology goes, if there is something that I don't understand I just sit and I re-read it and I re-read it and then it's almost like parrot fashion but hopefully it sinks in. (Int 8)

I love the practical, absolutely love it. My background has been community. I've had the chance to go onto the wards to see how the other half live and I love that, I think it's brilliant, I like the experience I'm getting, I've been into theatre and I've watched operations and I love all that, I hate the writing up, I hate it, there isn't enough hours in the day to work, and my home life, to write up what I've seen, make sense of it, do the referencing and it's just...that's where the pressure comes. (Int. 9)

However, there were numerous examples where students had successfully applied 'formal learning' to a practice context and appreciated the greater insights this gave them.

Community

To some extent these student nurses were positioned in a space at the periphery of both their practice learning community and the knowledge community. The support they needed to meaningfully engage in both came to a great extent from their peer group. Using a communities of practice model therefore reinforces the need to put in place structures and policies to promote peer interaction. There is a danger in seeing the sort of 'meaning making' students engage in as having a lesser status and importance than meaning making within established professional and knowledge communities. Clearly individuals need to have routes to engagement in both but this shouldn't be a one way street. There was clear evidence that students needed the space for informal reflection outside a formal academic framework to give them confidence and a foothold into more formal academic discourses. There was also evidence that there was resistance to more abstract forms of knowledge such as biology and therefore a need to develop strategies for meaningful engagement.

7. Further areas of investigation

Utilising Wenger's notion of communities of practice has enabled the transcripts to be analysed from a different perspective that has put more onus on organisational structures and policies to promote active communities of practice and hence individual, collective and organisational resilience. However, throughout there have been hints of even broader issues about 'meaning making' within and outside the immediate community of practice that could entail drawing on frameworks that explore further 'language, literacy, discourse and power and understanding of the broader social context in which communities of practice are located' (Barton and Trusting, 2005). This doesn't mean that insights from other perspectives should be ignored but that there is further work to be done to develop a fully integrated framework to provide the full range of conceptual tools that are needed to fully understand emotional resilience.

Table 1

Nature of adversity - stresses of student experience

| Category | Dimensions associated with stress |
|--------------------------------|--|
| Personal | <ul style="list-style-type: none"> • 'Drowning' in heavy workload • Adverse effects on family and social life • Financial worries • 'Double burden' - expectations that they would undertake caring roles within family |
| Academic stresses | <ul style="list-style-type: none"> • Challenge of academic work- disappointing results result in a grieving process, • 'Nightmare' of exams • Not seeing the relevance of aspects of curriculum. • Understanding and reaching requirements related to academic levels. • Unexpected changes to programme • Anticipatory stress related to student 'rumours'. |
| Reality of practice as student | <ul style="list-style-type: none"> • Challenges in gaining a student identity • Feeling out of place in practice • Feeling isolated • Organisational constraints • Stereotyping and prejudice • Experiencing negative attitudes • Fear of losing own 'caring' attitudes • Guilt feelings about responding inadequately to patient needs • Emotional labour associated with caring for dying and very ill patients, managing intimate care, and in identifying with experiences of others. • Tensions associated with ethical dilemmas – no 'black and white' answers • Difficulty in communicating about traumatic events • Learning to speak a different 'language' • Tension between taught or espoused philosophy and practice |

Table 2 Overall categories and properties/ dimensions which promote resilience

| Ways of 'being' | Personal survival tactics | Support provided by immediate work, social and educational environment | Wider social and cultural dimensions |
|---|---|--|---|
| <p>Being determined and highly motivated, if necessary, 'gritting your teeth' and 'going the extra mile'</p> <p>Being able to keep focused and your eye on reaching the final target</p> <p>Being self aware and possessing a positive self image and self confidence</p> <p>Developing and using emotional capital</p> <p>Being able to keep your emotional balance and to 'pick yourself up'</p> <p>Being mature and 'down to earth' - able to recognise the value of and use own life experiences.</p> <p>Having a sense of humour</p> <p>Having a positive attitude and being enthusiastic and flexible.</p> <p>Being able to respond to unpredictable and challenging situations</p> | <p>Finding ways of coping with identity change and ambiguity over role by clarifying / explaining to others.</p> <p>Able to adapt, restructure thinking in order to engage with and reframe problems</p> <p>Able to engage in skills of tact, diplomacy and negotiation</p> <p>Able to maintain boundaries between home, work and study – setting clear parameters, learning to juggle.</p> <p>Able to build relationships with others in working situations and also with fellow students.</p> <p>Able to utilise strategies for responding to negative stereotypes and attitudes</p> <p>Recognising learning as an active two way process - being able to make things happen by asking questions, showing interest</p> <p>Having the opportunity to pursue outside interests</p> <p>Making time for physical exercise and/or relaxation</p> | <p>Peer support vital – first point of call for help - dyads or larger group support.</p> <p>Network of family and friends to help to get things in perspective.</p> <p>Empathetic mentor support motivates, builds confidence, and facilitates opportunities.</p> <p>Feedback from service users</p> <p>Help from Programme Tutor who understands students and the programme and is approachable realistic, and flexible - gives advice, clarifies and an organisational problem – solver.</p> <p>Other tutorial support – understanding of particular needs, non – authoritarian, clarify, explain.</p> <p>Tutorials – advantages but limitations.</p> | <p>Positive culture of workplace learning</p> <p>Shifting status between non professional and professional identities</p> <p>Discourses relating to success and professional recognition – individuals develop resilience by positioning themselves within these discourses</p> |

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Framework of questions for focus group participants

1. Can you each give me a few words/ adjectives which best describe your work as a student nurse in practice.
2. Can anyone describe any practice situation which they found particularly challenging?
3. Is that a common experience?
4. Other challenging incidents?
5. Are there any other aspects of your work which cause you particular concern?
6. What helped you to cope with those difficult times?
7. What kind of person does a student have to be in order to cope well with difficult nursing situations?
8. Has your experience as student nurse changed the ways in which you handle problems or difficult situations?
9. What impact has your academic work had on the way in which you handle situations in practice?
10. Who gives you most support? What is most helpful?